Special Dietary Needs

In coordination with the Child and Adult Care Food Program

Child's full name: _____

Child care business name: _____

This child care facility participates in the Montana Child and Adult Care Food Program (CACFP). This facility is required to serve meals and/or snacks according to federal regulations and State agency policies. If a child has special dietary needs due to a medical diagnosis, food allergy, food intolerance, a disability, or other, it must be requested in writing by a parent/guardian and/or by a recognized medical authority/health professional (e.g. licensed physician, registered dietitian, physician's assistant, public health nurse, nurse practitioner). This form is required for all special dietary needs. If related prescriptions, instructions, or notes are received, they must be attached to this form.

Parent/Guardian Section

I have received information about the Health Insurance Portability and Accountability Act (HIPAA) and the privacy of my child's Protected Health Information (PHI). I understand that information regarding my child's food allergy and/or food substitutions will be shared with this facility's staff and including all staff who prepare and serve food at this facility. I further understand that my child's name and his/her special dietary needs and food and feeding instructions listed below will be posted in the kitchen, dining, and classroom areas to ensure that my child's safety is maintained at all times.

Food allergies: _____
Food intolerances: _____
Other reason or condition: _____

Request for foods to avoid, foods to substitute, special formulas required, or instructions for modification of food or feeding (attach additional information if necessary)

_____
_____
_____

Parent/Guardian Signature _____ Date _____

Medical Authority / Health Professional Section

Medical diagnosis: _____
Other reason or condition: _____
Special dietary requirements: _____

Additional information and instructions (attach additional information if necessary)

_____
_____
_____

Medical Authority / Health Professional:

Signature _____ Date _____
Address _____ Tel. _____

Retain original in child's file

Special Dietary Needs

In coordination with the Child and Adult Care Food Program

Child care business name: _____

Notice of Use of Protected Health Information

Effective Date: 4/14/2003

HIPAA / PHI:

Your child's privacy and the protection of his/her health information are important to this facility. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we are required to maintain the privacy of your child's Protected Health Information (PHI) and to provide you with this notice regarding our practices with respect to your child's PHI. This notice describes how your child's medical information may be used and disclosed, and how you can get access to this information. Please read this notice carefully.

This facility may receive PHI from your child's medical providers as part of the requirements of the program or to better meet your child's individual needs while s/he is enrolled at this facility.

This facility maintains an efficient and effective record-keeping system with policies and procedures that provide information about who has access to children's files and the information in them. All staff members who may have access to children's files will abide by our confidentiality policy.

If you think that some of the information on file as PHI is wrong, you may request in writing that it be changed or new information be added.

This facility will share information with staff only on a "need-to-know" basis to perform child care duties. The sharing of any PHI is to ensure that your child's health needs are met and their safety is maintained at all times. Any information shared with others is shared only after a Release of Information form is signed by the child's parent or guardian.

This facility will share information which may include PHI with individuals, agencies, and/or teams who oversee this facility for compliance, licensure, and inspections. Examples of these are: the Montana Child and Adult Care Food Program, County or State Health Department(s), Indian Health Services, Tribal Health Departments, and the Montana Quality Assurance Bureau.

This facility allows you to inspect your child's file containing PHI at any time with the assistance of a staff member. This facility maintains a log of all incidences of sharing PHI. You can request and receive a list of where your child's PHI has been shared.

If you have concerns about this notice, please ask the individual providing it. If that person cannot answer your questions, please call the Montana Department of Public Health and Human Services (DPHHS) PHI Officer at 1-800-645-8408.

To file a complaint regarding health privacy violations, write to the 'Secretary of Health and Human Services, US Department of Health and Human Services, 200 Independence Avenue SW, Room 506-F, Washington, DC 20201'. This must be done within 180 days from the date you believe your child's health privacy was violated. You may also call the Office of Civil Rights at 1-866-627-7748. This facility will not retaliate in any way if you file a complaint.

I have been given a copy of this Notice and have been given the opportunity to ask questions concerning how my child's PHI will be used. I know that I can contact this facility's director or the DPHHS PHI Officer at (800) 645-8408 if I have further concerns.

Parent signature is required on reverse side